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An investigation into the relationship between avoidant/ restrictive food intake disorder (ARFID) and children with Autism Spectrum Disorder (ASD)

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Student declaration

Undergraduate Dissertation Certificate



Name of the Programme of Study: Health Nutrition and Lifestyle

Name of Student (Capital Letters):

DECLARATION

I certify that the whole of this work is the result of my individual effort, and that all sources have been acknowledged.

Signed MARALYN ANDERSON (Student)

Date 16/04/2026

DECLARATION

I am satisfied that this work is the result of the Student's effort.

Signed (Lecturer)

Date

Abstract

The aim of the research was to investigate the co-occurrence of avoidant/ restrictive food intake disorder (ARFID) and children with autism spectrum disorder (ASD). The study's main aim and focus was identifying which out of the three subtypes of ARFID (sensory-based avoidance, lack of interest or fear of adverse consequences) was the most prominent within the children and what mechanisms are contributing to feeding difficulties.

The study adopted a mix-method approach, where quantitative data from the ARFID Brief Screener (Appendix 1) was used with (n=20 caregivers of children aged 3-6). For the qualitative data two semi-structured caregiver interviews was conducted.

Quantitative data was analysed using descriptive statistics, due to the small number of participants the researcher was able to tally up frequency scores and percentages were calculated to identify the most common ARFID subtype and to explore any overlap in ARFID presentations. A thematic approach was analysed in the qualitative interview data, this method was chosen for exploring lived experiences in families, this was to capture an in-depth of understanding that the questionnaire simply could not capture.

Finding from the research found that sensory-based avoidance with the primary driver in ARFID subtypes (60%) of children had demonstrated, followed by a lack of interest (50%) while fear of aversive consequences was less common (15%) and did not occur independently. Results also show an overlap in ARFID subtypes; this suggests that feeding difficulties in children that have ASD can be multifactorial. This is where thematic analysis had identified key contributing factors which included sensory sensitivity, interoceptive, and gastrointestinal issues and behavioural rigidity.

Overall, the findings support existing literature showing there is a strong association between ARFID and ASD with sensory processing as the primary driver. Therefore, the study highlights significant approaches are needed in clinical awareness, to identify, treat, and prevent chronic health outcomes in later life. Multidisciplinary intervention is needed to address severe eating difficulties within this population. Further research is needed to gain further understanding in ARFID's complexities within this population.

Search results

Utilising databases, PubMed, National Library of Medicine, Journal of Autism and Developmental Disorders, Google Scholar.

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I would like to thank all my lectures and tutor for the support and guidance, you have all given me the confidence to believe in myself and I can achieve, I am so very grateful.

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Chapter 1 Introduction

The purpose of this study is to investigate the relationship between avoidant/ restrictive food intake disorder (ARFID) and children on the autism spectrum disorder (ASD), the aim is to examine the reason for their co-occurrences with a focus on sensory, behavioural, and physiological factors, that may contribute to feeding difficulties. The study also aims to understand how ARFID presents in children with ASD and to explore the mechanisms and lived experiences associated with feeding difficulties within this population.

The research objective of this study is to review existing literature on the co-occurrence of ARFID and autism. To examine the prevalence of ARFID in children with ASD aged 3-6 using the ARFID Brief Screener questionnaire (Appendix 1) to find if it correlates with current research.

To analyse which subtype of ARFID sensory, lack of interest, or fear of adverse consequences are the main sub drivers to contribute to feeding difficulties. To identify the main ARFID subtypes, or over lapping subtypes most commonly observed in this group. To explore caregiver's experiences, perception on the causes, and how these impacts on daily life in managing feeding difficulties in ASD children.

The study objective is to understand the acute and chronic complications that comes with the severity of feeding difficulties such as gastrointestinal issues such as sever constipation, reduced bone mineral density, poor micro and macro nutrients intake with the possible outcome of malnutrition or obesity, and hormonal disturbances such as poor growth and delayed puberty within females.

And lastly to discuss the clinical implications of assessments, diagnosis, and early intervention, in order to gain increased knowledge on both conditions, so informative, and appropriate intervention strategies in future can help to prevent nutritional deficiencies, growth disruption, and compromised cognitive health in children.

1.1 Autism

Autism Spectrum Disorder (ASD) is a neurodevelopmental condition characterised by early-onset neurodivergence associated with restrictive behaviours, social communication difficulties, and repetitive behaviours (Passarini, 2025). ASD is a lifelong neurological condition for which there is no cure (Qin, 2024). Prevalence estimates vary, but it is suggested that approximately 1% of children in the UK are autistic (Arribas-Ayllon, 2025).

1.2 ARFID

Avoidant/restrictive food intake disorder (ARFID) is a serious diagnosable eating disorder (Nicholls-Clow, 2024). It is a complex and psychological condition that stems from interconnected biological, psychological, and environmental factors (Bryttek-Matera, 2022). The primary psychological reason for ARFID is categorized by three main subtypes: fear of aversive consequences, sensory-based avoidance, and lack of interest in food (Bryttek-Matera, 2022).

Fear of aversive consequences can develop an intense anxiety or phobia contributing to potential negative outcomes of eating (Gianneschi, 2024). This can be triggered by traumatic past experiences with food (Gianneschi, 2024). Thus, leading to exaggerated fear responses in the brain (Menzel, 2024). The fear of aversive consequences can lead to a fear of choking or gagging, vomiting, nausea, gastrointestinal issues, or food allergies. This can make eating unpleasant or even painful leading to avoidances of certain foods or eating in general (Menzel, 2024).

Sensory-based avoidance is related to taste, smell, or appearance, reactions to certain tastes, smells, or even colour of food can have a negative response leading to avoidance of food that triggers the individual (Menzel, 2024).

Lack of interest in eating is related to a general disinterest in food and eating, or an inability to recognize normal hunger cues (Ramirez, 2024). This can be perceived eating feeling like a chore as it does not provide pleasure or reward signalling in the brain (Ramirez, 2024). Poor appetite, feeling full after only a few mouthfuls of food or

not feeling hungry in relation to how others would, or forgetting to eat for long periods of time (Ramirez, 2024).

ARFID was formally introduced as a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* in 2013 (Seetharaman, 2020). The co-occurrence with other psychological and neurodevelopmental conditions may contribute to the development or presentation of ARFID (Luzio, 2026; Nyholmer, 2024). Conditions that are highly linked are anxiety disorders, ASD, attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD) (Luzio, 2026; Nyholmer, 2024).

Despite increasing awareness in the UK, ARFID is not currently included in autism assessment criteria, nor is autism routinely screened for during ARFID assessments. While the topic is gaining attention within the medical community, international symposiums and discussions regarding the treatment of ARFID in autistic individuals are still emerging (Bourne, 2022; Kozak, 2023; Nicholls-Clow, 2024 Sader, 2025).

1.3 Co-occurrence of ARFID and Autism

ARFID can affect individuals of all ages and backgrounds; however, its prevalence is notably higher within the autistic population. this increased prevalence is thought to arise from overlapping characteristics shared by both conditions (Sader, 2025). Restrictive behaviours present in both ARFID and autism can be more severe than those observed in neurotypical individuals. Autistic individuals often rely heavily on routines and rituals, which may manifest as rigid mealtime schedules, specific food preparation methods, and limited food variety. Deviations from these routines can result in significant distress and anxiety (Koomer, 2021).

1.4 Diagnostic measures

Eating disorders and feeding difficulties have long been a public health concern, traditionally associated with anorexia nervosa and bulimia nervosa due to body image dissatisfaction (Passarini, 2025). However, ARFID differs in that restrictive eating is not motivated by weight or shape concerns, but rather by psychological and physiological factors (Kambanis, 2025).

Despite its recognition, ARFID remains poorly understood and under-researched (Kambanis, 2025). Its lack of association with body image concerns often leads to misinterpretation by both the public and healthcare professionals, resulting in misconceptions such as labelling affected individuals as “picky eaters” or assuming the behaviour will resolve naturally (Ramirez, 2024). Such misunderstandings can increase the risk of rapid weight loss, malnutrition, and long-term health complications (Ramirez, 2024).

Chapter 2 Review of Literature

2.1 Aims of literature research

The aim of the literature research is to identify what current literature has discovered in the co-occurrence of ARFID representations within autistic children and what subtype is the most prevalent. The aim is to find out if current literature and research is consistent within this study. The aim is to gain greater knowledge on the complexities of ARFID and ASD and its comorbid mechanisms, and what strategies can be put in place to identify, so conditions do not worsen.

2.2 Inclusion and Exclusion Criteria

Table 1 Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Published research in literature review, between the dates of 2021-2026, English language of journals, books which aimed to explore, explain or evaluate the co-occurrence of ARFID in children with ASD experiences with feeding habits, what subtype is most prevalent sensory-based avoidance, lack of interest, and fear of aversive consequences.	Research before 2021, Sources that are not in the English language, Research relating on eating disorders but not ARFID, Research relating to ARFID to children without a diagnosis of ASD.
Qualitative and quantitative studies of any research design was researched.	Children were excluded who were under the age of 3 and over the age of 6.
Participant within the researcher's study must be mothers of children with ASD and between the age of 3-6 years.	Children who do not have a diagnosis of ASD.
	Children that have ASD but do not have feeding difficulties.
	Parents or caregivers that are unable to complete study procedures.

Children must have a diagnosis of ASD. Children must fit the criteria of suspected ARFID. Parent or primary caregiver must provide consent to provide the researcher information on the child's eating behaviour. Twenty parents must fill a questionnaire (ARFID Brief Screener) to Identify if there are ARFID symptoms present. Two parents must take part in interviews to identify certain behaviours towards foods.	Researchers' opinion was excluded.
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2.3 Introduction

This chapter presents a literature review exploring the prevalence of ARFID in autistic children and the mechanisms underlying their co-occurrence. It examines how ARFID affects both physical and psychological wellbeing, identifies which ARFID subtypes most strongly correlate with autism, and investigates nutritional status and common deficiencies within this population.

The review further explores risks associated with malnutrition, potential long-term health consequences such as obesity, impaired gut health, reduced bone density, and increased risk of chronic disease. Additionally, it considers the impact of ARFID on mental health, the development of comorbid psychological conditions, and how affected children perceive and experience the condition. Finally, key findings regarding Which ARFID subtype (sensory-based avoidance, fear of aversive consequences, low interest in food) is most prevalent in autistic children. What treatment approach works, and the effectiveness of early intervention strategies are discussed.

2.4 ARFID

ARFID is a severe eating disorder characterised by a highly restrictive diet that is not driven by concerns related to body image- or body dysmorphia (Ramirez, 2024). ARFID involves a persistent failure to meet nutritional needs due to avoidance or

restriction of food intake. The condition is commonly categorised into three subtypes: avoidant (sensory-based), aversive (fear-based), and restrictive (low interest in food) (Ramirez, 2024).

2.5 Mechanisms Underlying Co-Occurrence

ARFID frequently co-occurs with autism, and underlying neurological factors related to sensory processing (avoidant), behavioural rigidity (restrictive), and physiological sensitivities may contribute to its development in autistic individuals (Passarini, 2025). Autistic people often experience multiple psychiatric co-occurrences, including feeding and eating disorders (Petersen, 2024). Research indicates that characteristics associated with ARFID such as feeding difficulties and restrictive eating behaviours are significantly more prevalent among autistic individuals (Sader, 2025). This overlap is likely due to shared features, including sensory sensitivity and cognitive rigidity. Despite this, ARFID remains under-recognised and underdiagnosed within the autistic population (Tanaka, 2025).

Based on recent meta-analyses (2025), ARFID prevalence in general population is estimated at 0.3%-15.5% in general and often prevalent in younger populations (Cerezo *et al*, 2023; D'Adamo, 2023; Wilkinson, 2025). Within the autistic population ARFID prevalence is much higher, it is estimated at approximately 11.41% to over 20%, with even some studies with 16% of those with ARFID and diagnosed with ASD this suggests a strong association between ARFID and ASD (Ozel, 2025; Sader, 2025). However, studies have shown there are a lot of variability between studies, and the exact prevalence is uncertain the statistics show wide results in ARFID and ASD groups it falls within 2.89%-35.76% making the true value possibly to be much higher or lower (Sader, 2025).

Based on recent research the most common subtype of ARFID in this population is sensory sensitivity subtype and a lack of interest in eating alongside a combined subtype while less common fear-based avoidance was presented more as a comorbid contribution associated with anxiety, or obsessive-compulsive disorder (Sanchez-Cerezo, 2024). The reason for this is there is simply not enough limited data to compare to general population many studies have concluded in their work that more research is needed within this field of research (Koomar, 2021; Sader, 2025; Thomas, 2017).

There can be a number of reasons why results vary, this could include gender and ethnicity influence, this may have contributed to differences between studies and prevalence may vary across demographic groups with some populations being more represented or underrepresented within research groups (Sader, 2025). The research found frequently used within the data was numerical while known for its reliable use for results and prevalence rates it does not have its variability and lack of specificity as qualitative results can give data that can gain a deeper understanding between the two conditions and how their subtypes co-occur with only a handful of research indicating findings highlight a significant rate of the two conditions co-occurrence, the suggestion is to increase further research, and consider clinical settings that screening ASD individuals for ARFID or vice-versa to investigate further (Bamigbade, 2024; Sader, 2025).

2.6 Diagnostic measures

There are significant challenges in diagnosing ARFID in autistic children (Passarini, 2025; Rajendram, 2021). This can derive from the high degree of symptom overlap as many core traits of ASD, such as sensory sensitivity to texture, smell, colour, and the need for rigidity are also the primary drivers of ARFID (Sader, 2025). This can cause diagnostic overshadowing; and can attribute to clinicians mistaking severe restrictive eating habits solely to ASD (Rajendram, 2021). This can potentially be missed with co-occurring symptoms of ARFID that requires specific and specialised treatment (Rajendram, 2021). Which in turn can result in delayed treatment and can significantly impact developmental trajectory and impact growth (Rajendram, 2021).

Research has highlighted that parents of autistic children often report needing to advocate strongly for further medical investigation (Bamigbade, 2024; Kluber, 2025). including nutritional assessments and referrals to dietetic services. This may reflect a tendency within healthcare settings to prioritise the primary diagnosis of autism, potentially overlooking co-occurring conditions such as ARFID (Koomar, 2021).

In some cases, healthcare professionals may attribute restrictive eating behaviours primarily to autism (Johnson, 2022). which can delay or limit further assessment for ARFID or related nutritional concerns. Consequently, parents and caregivers may

need to actively request additional investigations, such as blood tests or specialist referrals (Ramirez, 2024).

As there is a lack of standardized guidelines for how to apply the DMS-5 criteria specifically to ASD this clearly indicates a lack of diagnostic boundaries between the two complex conditions (Thomas, 2019; Passarini, 2025; Rajendram, 2021).

Diagnostic services are often limited by insufficient resources and a shortage of trained professionals able to conduct assessments, making it difficult for individuals and families to access timely and appropriate support (Arribas-Ayllon, 2025).

Autistic individuals are at increased risk of developing psychiatric conditions if early intervention is not provided (Passarini, 2025). These include anxiety disorders (30–39%), depression (15–21%), suicidal ideation and attempts (1–66%), psychotic disorders such as schizophrenia (7–13%), obsessive-compulsive disorder (7–10%), attention-deficit/hyperactivity disorder (ADHD) (28–46%) (Passarini, 2025), and eating disorders (28%) (Santos Junior, 2025; Watts *et al*, 2023). Early intervention is critical in reducing the risk of severe psychiatric outcomes during adolescence and adulthood (Whitehouse, 2021).

Many studies have found that early intervention is crucial, interventions delivered during early childhood can utilise the brain's neuroplasticity to support foundational skill development and reduce secondary challenges later in life (Suprunowicz, 2025). Evidence suggests that intervention before the age of three is particularly important for optimal developmental outcomes (Lidstone, 2025). However, findings indicate that only 15% of children receive early intervention, and among those who do not, 15.5% experience a worsening of ASD symptoms (Lidstone, 2025).

Earlier diagnosis is associated with improved outcomes for both children and families and a reduction in secondary difficulties (Lidstone, 2025). Diagnosis before the age of two is especially beneficial due to peak brain development occurring during this period (Lidstone, 2025).

2.7 Challenges when no diagnosis is present

Persistent nutritional inadequacy associated with ARFID can lead to malnutrition (Johansson, 2023), physiological and metabolic complications (Johansson, 2023),

gastrointestinal issues such as severe constipation and abdominal pain due to low fibre intake (Johansson, 2023), reduced bone mineral density (Proctor, 2023), and hormonal disturbances, particularly in females, including amenorrhoea and delayed puberty (Aulinas, 2020).

Given the strong association between ARFID and ASD, there is a growing need to understand the relationship between these conditions (Sader, 2025). Autistic individuals often experience heightened difficulty coping with uncertainty and unexpected change (Chen, 2024), leading to reliance on routines as a mechanism to reduce anxiety (Chen, 2024). In some cases, control over food intake may serve as a coping strategy, providing a sense of stability when other areas of life feel overwhelming (Brede, 2020).

2.8 Nutritional Consequences and Physical Health Impact

ARFID in autistic children can become severe and may develop into a chronic eating condition (Thomas *et al.*, 2017). It is often driven by intense sensory sensitivities, a lack of interest in eating, or fear of adverse consequences such as choking or vomiting. These factors can result in highly restrictive eating behaviours that significantly affect nutritional intake and overall wellbeing, leading to nutritional, physical, and psychosocial impacts (Watts, 2023).

In severe cases, malnutrition and weight loss may occur, which can lead to faltering growth or rapid weight decline (Bryant-Waugh, 2021). Nutritional deficiencies can develop quickly when the child enters a highly restrictive phase of eating. Cardiovascular complications such as bradycardia and hypotension may develop due to malnutrition, where heart rate and blood pressure decrease, often resulting in fatigue, dizziness, and reduced physical functioning (Norris, 2021).

Electrolyte imbalances may also occur due to insufficient levels of potassium, sodium, and calcium, which may be further exacerbated by dehydration (Norris, 2021). These imbalances can lead to symptoms including muscle weakness, irregular heart rhythms (arrhythmias), palpitations, and impaired neurological functioning that can affect concentration, cognition, and energy levels (Friars, 2023; Burton-Murray, 2024).

Several micronutrient deficiencies are commonly associated with ARFID in children due to the limited variety of foods consumed which can lead to malnutrition, obesity, weight loss, and stunting in growth (Nogueira-de-Almeida, 2025).

Vitamin C deficiency may lead to scurvy, a systematic review of 76 cases of children with ASD and AFRID discovered high rates of severe nutrient deficiencies with 69.7% having scurvy while inadequate vitamin A intake of 17% resulted in visual impairments and reduced immune function (Yule *et al*, 2021). Deficiencies in vitamin D, vitamin B-12, and thiamine was 62.9% of children and adolescents (Yule *et al*, 2021).

The inadequate intake of food may lead to low poor bone mineralisation and increase the risk of rickets or weakened bone development due to low calcium and can result in long term conditions such as osteoporosis (Nogueira-de-Almeida, 2025). Additionally, inadequate intake of B-vitamins, folate, iron and zinc, may affect neurological functioning, red blood cell production, and overall energy metabolism (Burton-Murray, 2024; Nogueira-de-Almeida, 2025).

Autistic children are four times more likely to experience gastrointestinal (GI) issues (Tomaszek, 2025). These can include constipation, diarrhoea, and abdominal pain, which can be further exacerbated by ARFID (Tomaszek, 2025). Poor nutrition is often associated with an imbalance in the gut microbiome, which may in turn affect the gut–brain axis, often referred to as the “second brain” (Petropoulos *et al.*, 2025). This is commonly linked to ASD, as feeding difficulties can become severe. The gut–brain axis in ASD refers to the bidirectional communication between the gut microbiota and the brain, where gut dysfunction, known as dysbiosis, may occur (Petropoulos *et al.*, 2025).

Disruptions in this axis can potentially be linked to inflammation and metabolic products, which often correlate with both internal and external factors. This may ultimately result in worsening symptoms such as behavioural difficulties, speech challenges, sleep disturbances, reduced focus, and dysregulation of the nervous system (Petropoulos *et al.*, 2025; Tomaszek, 2025).

Several studies have compared autistic children with neurotypical (NT) children in relation to food rejection and selectivity. One study found that 78% of autistic children avoided at least one food group, with vegetables being the most commonly rejected (Tomaszek, 2025). With increased difficulties in introducing new foods, this can result in strict preferences in the choice of foods which may lead to processed, sweet, and soft foods which contain high energy-dense foods and high carbohydrate intakes this can ultimately lead to excessive weight gain or obesity (Nogueira-de-Almeida, 2025).

Additionally, 60.6% of autistic children showed food selectivity compared to 39.9% of NT children (Tomaszek, 2025).

Interventions aimed at improving the gut microbiome through a modified diet, including probiotics, symbiotics, or microbiota transplants, may help improve inflammation in the gut. This may reduce activation of the nervous system's fight-or-flight response and lead to improvements in mood, speech, sleep, and focus (Petropoulos *et al.*, 2025).

Sensory sensitivities can further exacerbate eating difficulties. Difficulties processing multiple sensory inputs during meals may lead to sensory overload, contributing to food avoidance, reduced appetite, and food neophobia (Koomar, 2021). Research indicates a high level of overlap between autism and ARFID, with estimates suggesting that approximately 21% (1 in 5) of autistic children meet criteria for ARFID (Koomar, 2021).

2.9 Sensory Processing Differences

Autistic individuals experience the world differently compared to neurotypical individuals (Trancon, 2025). This is related to the eight sensory system, while neurotypical people generally experience their senses automatically and without conscious thought, autistic individuals often experience senses differently, with hyposensitivity (under-responsive) or hyper-sensitivity (over-responsive) (Trancon, 2025). Most people only learn about the five sensory systems commonly known and learned in school, such as visual (sight), auditory (hearing), tactile (touch), olfactory (smell), gustatory (taste) (Trancon, 2025). Nonetheless there are three internal senses that the body relies on to navigate the world and maintain internal balance otherwise known as homeostasis (Loureiro, 2024).

2.10 Interoception and low Interest Subtype

The first internal sense is interoception known as the eighth sense (Mahler, 2022). Interoception allows the brain to interpret signals from inside the body, such as hunger, fullness, thirst, pain, or the need to use the bathroom this interacts with ARFID and autism through the lack of feeling their internal needs when for instance feeling hungry or full (Loureiro, 2024; Mahler, 2022). This can come under the subtype of lack of interest in food in ARFID (Adams, 2022).

2.11 Motor, Proprioceptive, and Sensory Factors

Proprioception is body awareness; this sense is related to body position and movement; this allows the body to know body parts are without looking, proprioception be related to processing and regulation (Riquelme, 2024). This link with ARFID and ASD can lead to discomfort during the act of eating such as how mouth, jaw, and tongue interact with food (Kozak, 2023). It may influence food preferences such as crunchy or soft foods that is linked to sensory seeking (Kozak, 2023). Or it can be linked to physically feeling uncomfortable sitting still at the table thus the need for standing or moving while eating (Kozak, 2023).

Vestibular sense is linked to balance and movement (Chisari, 2024). Vestibular system is located in the inner ear; this helps with balance and motor skills (Chisari, 2024). If a person vestibular is dysregulated, it can contribute to a high-stress state and can cause sensory over-load to environmental factors such as lighting or noise, and food characteristics to texture and smells during meals thus exacerbating to the avoidance of food (Ingrosso, 2024; Karaca, 2025).

Oral moto function maybe delayed and the muscles within the oral area maybe inefficient, thus the need for the same foods which could lead to soft foods and a high intake of carbohydrates or high in fat foods, with limited vegetables which in turn can lead to malnutrition or becoming overweight or obesity (Karaca, 2025).

2.12 Anxiety and Fear-Based Avoidance

Fear of aversive consequences (FOC) involves a restriction of food due to the fear of choking, vomiting, or pain (Menzel, 2024). ARFID and its comorbidity are commonly linked to mental health, or development conditions (Menzel, 2024). Some 45%-95% of people with ARFID will also have another psychiatric condition, with anxiety disorder being the most common (Menzel, 2024). The condition of ARFID rarely happens on its own and different ARFID subtypes tend to connect to different mental health conditions (Menzel, 2024).

Fear based avoidance is commonly linked to mental health conditions such as anxiety (Nocerino, 2024). While sensory based is highly linked with ASD, and lack of interest highly links to ADHD, ASD, and depression (Dinkler, 2022). However, ASD can have a high prevalence in any subtype or even all three (Dinkler, 2022). Ridged routines and the preference for sameness can cause a restriction in the diet, as fear can be

associated with trying new foods or changed a type of food that is familiar resulting in intense anxiety to the individual (Dinkler, 2022) With many studies showing that autistic children present restrictive and repetitive behaviours (RRBs), are strongly correlated with ARFID risk (Menzel, 2024; Watts, 2023).

2.13 Sex differences in ARFID and ASD

Sex differences also influence autism diagnosis, with males more likely to receive a diagnosis than females. This disparity is attributed to a combination of genetic and diagnostic factors (Fredriksen, 2025). Current diagnostic data suggest a ratio of approximately four males to every one female are diagnosed with ASD (Fredriksen, 2025). Studies indicate that ARFID is most prevalent in children with autism and the common age is 4-9 years with a higher occurrence in males (Sader, 2025).

Females can often engage in “masking” behaviours consciously or unconsciously concealing symptoms which can delay diagnosis and increase vulnerability to anxiety, depression, and eating disorders in later life (Fredriksen, 2025; Galvin, 2022).

Research has shown that ARFID may progress into more severe eating disorders, such as anorexia nervosa (Kambanis, 2024). Medical professionals are often the first to identify autistic traits in individuals presenting with eating disorders (Parson, 2023). Between 2020 and 2022, approximately 10% of females hospitalised for severe eating disorders were later identified as autistic (Parson, 2023).

Chapter 3 Methodological Approach

The research considers an interpretivism paradigm approach exploring lived experiences through in-depth interviews in order to investigate life histories in relation to wider medical, social, economic and political landscapes (Lor et al., 2025; Lanford et al., 2025).

3.1 Participants and Setting

Participants were mothers or primary caregivers of children formally diagnosed with ASD. Recruitment took place within a charity community associated with a primary school in Swansea, Wales. Participants were recruited through voluntary participation, ensuring that individuals had direct experience relevant to the research aims.

A sample of 20 caregivers completed the ARFID Brief Screener (Appendix 1), which was used to assess feeding difficulties in autistic children aged 3 to 6 years. The screener enabled the identification of symptoms associated with avoidant/restrictive food intake disorder (ARFID), including sensory-based avoidance, low interest in food, and fear-based avoidance, as well as potential overlap between subtypes.

Two caregivers participated in in-depth semi-structured interviews (Appendix 2 and Appendix 3). These interviews provided rich informative and detailed accounts of lived experience, aligning with the focus on depth.

3.2 Thematic analysis

Thematic analysis was used in the form of interview transcripts; this was to get a true understanding of lived experiences from care givers thoughts on their child's behaviours and experiences in feeding difficulties. Thematic analysis is widely used and trusted for its flexible qualitative method for identifying, analysing, themes with responses. This is Dependability achieved through the creation of an audit trail to show how the transcripts of the interviews were examined using Braun and Clarks (2006) thematic analysis was used to identify themes within the responses. In this study dependability was supported by providing a clear description of the research design, data collection procedures, and data analysis methods (Ahmed, 2025). Information provided in the interviews guided the identification of themes which related to sensory sensitivity, mealtime distress, lack of interest in food, support for intervention, impacts

on daily social life for child and family (Table 5 and Table 6). Review of the literature (Chapter 2) identified using inclusion and exclusion criteria (Table 1) was instrumental in guiding the interview questions.

In order to establish trustworthiness of the research the method was considered in line with Lincoln and Guba (1985) who used the criteria of credibility, transferability, dependability and confirmability (Ahmed, 2024). Trustworthiness was considered throughout the research process to ensure quality and credibility of the study.

Credibility in this work was strengthened with a mixed-methods approach and was achieved through observation of the participants gained from in-depth interviews and questionnaires. The questionnaire approach was the ARFID brief screener test, a recognised screening instrument used to identify symptoms associated with ARFID (Alexander, 2019). The use of this measure was to enhance validity and reliability of the questionnaire as this specific questionnaire has been applied in previous research (Dinkler, 2022).

Structured interviews were conducted to provide a deeper understanding of the participants experiences and perceptions and allowing participants to expand on issues that are identified within the questionnaire (Monday, 2020; Valencia, 2022). Interviews were recorded and transcribed to ensure accurate representation of the participants response during the analysis (Monday, 2020; Valencia, 2022). Methodological triangulation between questionnaires and interviews further strengthens the credibility of the research (Valencia, 2022). It is valued for its cost effective and reliable data needed for gaining more in-depth and understanding in research (Monday, 2020).

Transferability was gained by providing clear descriptions of the research context, participant characteristics, and data collection methods. The sample size was relatively small and specific to the study population. This detailed presentation of participants experiences allows for an exploration of real-life experiences of a community of parents of children who have autism and ARFID (Alexander, 2019).

Confirmability findings were achieved through participant debriefs, rather than the researcher's bias. Within this study confirmability was supported by analysing the data systematically and ensuring that interpretations were grounded in participants

responses. Interview data was transcribed and analysis carefully to ensure that the participants perspectives was accurately represented. Qualitative research has limitations and researcher bias (Alexander, 2019) is addressed through the robust method to ensure trustworthiness and transparency of the data (Ahmed, 2024).

Recruitment was limited because the participants were recruited from one school community. However, the participants are arguably a representative sample of a community and therefore the significance of the results could be considered as a base line and a model for further studies.

A further limitation of this study is the reliance on parent-reported data, which may introduce proxy reporting bias. As the data was collected through caregivers rather than the children themselves, interpretations of feeding behaviours may not fully reflect the child's internal experiences, particularly in relation to subtypes such as fear of aversive consequences or lack of interest in eating. This is especially relevant given the young age of participants (3–6 years), as ASD children in this age group may have limited ability to communicate internal states such as hunger, anxiety, or discomfort. Consequently, there is a risk of misclassification of ARFID subtypes, as observable behaviours may be interpreted differently by caregivers.

3.3 Ethical Considerations

Ethical approval for this study was granted by the University of Wales Trinity Saint David (UWTSD, 2025) (Appendix 4). All participants were provided with a detailed information sheet outlining the purpose of the research, what participation involved, and their rights as participants. Written informed consent was obtained prior to data collection, and participants were given time to make an informed decision.

Participants were informed of their right to withdraw from the study at any point. To ensure comprehension, participants were encouraged to ask questions and confirm their understanding before consenting.

Confidentiality and anonymity were maintained throughout the research process. All data were anonymised, and identifying information was removed. Questionnaire data were securely stored in password-protected digital files and locked storage. Interview recordings were conducted with consent, securely stored, and permanently deleted following transcription.

Given the potentially sensitive nature of discussing feeding difficulties and caregiving experiences, participants were informed of available support services. The research was conducted in a charity community setting where professional support could be provided.

All data collected were used solely for academic purposes and shared only with the researcher's university. Participants were informed that they could request access to the study findings upon completion.

Chapter 4 Results

Table 2. Participant Demographics

Gender Number of Children Percentage (%)

Boys	13	65%
Girls	7	35%
Total	20	100%

Table 3. ARFID Brief Screener Results (Children aged 3–6 with Autism)

ARFID Presentation (from Brief Screener) Number of Children Percentage (%)

Sensory Sensitivity to Food	12	60%
Lack of Interest in Eating/Food	10	50%
Fear of aversive consequences	3	15%
Total Participants	20	—

Table 4. Overlap of ARFID Presentations (Children aged 3–6, n = 20)

ARFID Presentation Category	Number of Children	Overlap With Other Categories
Sensory Sensitivity Only	10	—
Lack of Interest Only	5	—
Sensory Sensitivity + Lack of Interest	2	Both sensory and lack of interest
Lack of Interest + Fear of aversive consequence	3	Fear of aversive consequence occurred within lack of interest

ARFID Presentation Category	Number of Children	Overlap With Other Categories
Fear of aversive consequence Only	0	—
Total Participants	20	

Note: Fear of adverse consequence did not occur independently and was only present in children who also showed lack of interest in eating.

Important Note: There were children with ASD present that had no symptoms of ARFID and had a wide variety in their diet they were not chosen due to what the researcher study was looking for. But this indicates that not all children that have ASD will have feeding difficulties, indicating that this is simply not due to the child's identification to autism.

Table 5. Main Thematic Findings from Interview (Parent 1)

Theme	Description	Codes	Example Evidence
Sensory- Based Feeding Difficulties	Feeding behaviours are strongly influenced by sensory sensitivities, particularly temperature, texture, and food appearance.	Sensory processing differences play a key role in food acceptance and avoidance.	"If it's too hot, she'll shout" "she eats super noodles cold." "She doesn't like anything really cold she won't eat ice cream." "She prefers soft foods like pasta and rice"
Restricted Diet and Reliance on "Safe Foods"	The child's diet has become increasingly limited over time, moving from a varied diet to restricted intake. The child depends on a narrow range of predictable, familiar foods and rejects variation.	Feeding difficulties developed gradually, consistent with ARFID onset patterns. Food choices are driven by routine and predictability, reflecting rigidity and safe food reliance.	She used to eat everything, then around 18 months it started to reduce." "Over time, things started coming out of her diet." food choices are driven by routine and predictability, reflecting rigidity and safe food reliance. "She mainly eats beige foods, pasta, rice, super noodles." "Only chicken nuggets from McDonald's not homemade." "Only certain crisps like Wotsits or Skips."

Mealtime Emotional Distress	Eating situations often result in distress, refusal, or behavioural reactions.	Mealtimes are associated with emotional dysregulation and stress.	“She gets really upset and has a meltdown if we go out for food.” “She’ll shout or refuse when trying new foods.”
Parental Anxiety and Emotional Burden	The caregiver experiences worry, stress, and emotional strain related to the child’s eating and nutrition	Feeding difficulties place a significant emotional burden on caregivers.	“It’s really upsetting as a mother.” “I worry about her nutrition... vitamins.”
Impact on Family Life and Social life	Feeding difficulties affect family routines, social activities, and experiences such as eating out or holidays.	ARFID-related behaviours extend beyond eating, impacting daily life and social engagement	“We can’t really go out for meals.” “Holidays were difficult she’d be screaming and shouting.”
Diagnostic challenging’s and lack of recognition	There is a lack of professional support, leaving parents to manage feeding difficulties independently	Diagnostic over shadowing; Lack of ARFID diagnosis.	“There’s no support for ARFID.” “It’s a guessing game.”

Table 6. Main Thematic Findings from Interview (Parent 2)

Theme	Description	Codes	Example Evidence
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Sensory- Based Feeding Difficulties	Feeding behaviours Are strongly Influenced sensory sensitivities (smell, texture, and food preparation)	Sensory- based, Smells of foods, rejection; texture Aversion; finger foods and dry foods as preference.	“If it doesn’t smell right, he throws it” “He won’t eat anything with gravy or sauce” “He eats mainly dry foods and finger foods”
Restricted Diet and Reliance on “Safe Foods”	The child consumes a limited range of foods and depends on familiar “safe foods” often rejecting meals.	Severely restricted diet on reliance on familiar foods; food rejection	“If I try to spoon-feed him, he will take the food back out of his mouth to feel it smell it again” “If its not to his liking he won’t eat it”.
Mealtime Emotional Distress	Mealtimes are associated with significant emotional dysregulation and distress during mealtimes.	Mealtime emotional Distress	“It results in screaming and hitting his head and kicking”.
Physiological factors that affect eating.	Physical health issues, including gastrointestinal difficulties, directly influence appetite and food intake	Physiological discomfort; Chronic constipation; Eating linked to bowel function.	“His eating depends on if he’s opened his bowels”
Diagnostic challenging’s and lack of recognition	Feeding difficulties are often attributed solely to autism leading to under recognition and lack of formal ARFID diagnosis.	Diagnostic over shadowing; Lack of ARFID diagnosis.	“Because he’s autistic they have put it down to sensory sensitivities linked to autism”

Chapter 5 Discussion

This study explored the prevalence and presentation of ARFID subtypes in autistic children aged 3–6 years, while also examining the underlying mechanisms and lived experiences associated with feeding difficulties. By incorporating both quantitative and qualitative findings, this study provides a comprehensive understanding of how ARFID shows within this population. Overall, the findings show that feeding difficulties in autistic children are complex and multifactorial, with sensory sensitivities emerging as the most prominent driver, alongside interoceptive differences, physiological factors, and environmental influences.

The purpose of this mixed method study was to identify, which of the three subtypes of ARFID identifies with autism. This section of this chapter includes a discussion of significant findings as related to the literature on what ARFID subtypes are predominantly related to children with autism while also examining the underlying mechanisms and lived experiences associated with feeding difficulties.

5.1 Results and Findings from ARFID Brief Screener

Overall, the results highlighted that ARFID presentations in autistic children are often overlapping rather than distinct categories. The findings indicate the importance of recognising the complexity of feeding difficulties in autism, as children may experience multiple contributing factors affecting their eating behaviours (Sanchez-Cerezo, 2024).

The findings indicate that sensory sensitivity to food was the most frequently observed, affecting 12 children in total. Of these, 10 children showed sensory sensitivity as their primary difficulty, while two children also demonstrated a lack of interest in eating. This suggests that sensory-related feeding challenges and lack of interest are particularly common among autistic children in early childhood (Sanchez-Cerezo, 2024).

Lack of interest in eating was reported in 10 children overall. Within this group, five children displayed lack of interest as their sole presentation. However, overlap with other ARFID characteristics was also clear. Two children who experienced sensory sensitivity also showed reduced interest in eating, indicating that multiple feeding difficulties can occur simultaneously (Sanchez-Cerezo, 2024).

Fear of adverse consequence was reported in three children, and in all cases this presentation occurred alongside a lack of interest in eating rather than occurring

independently. This may suggest that anxiety-related feeding concerns can contribute to reduced motivation to eat (Sanchez-Cerezo, 2024).

By integrating both quantitative and qualitative findings, this study provides a comprehensive understanding of how ARFID manifests within this population. Overall, the findings suggest that feeding difficulties in autistic children are complex and multifactorial (Table 3), with sensory sensitivities emerging as the most prominent driver, as evidenced in Sader (2026) which was supported by the evidence from the participants alongside significant contributions from interoceptive differences, physiological factors, and environmental influences (Adams, 2022).

The findings in the questionnaires of this study suggest that sensory sensitivity is the most prominent ARFID subtype in children with ASD with 60% of children whose parents completed the questionnaire experiencing sensory-based avoidance which strongly correlates with the literature findings (Dinkler, 2022; Sader, 2025). This supports the Theory of Core Sensory processing in ASD that highlights the struggles within this population with restrictive eating behaviours (Dinkler, 2022).

The findings of this study also suggest low interest-based avoidance correlates highly with ASD with 50% of children experiencing this subtype (Table 3). The evidence strongly relates to the literature findings and that interoceptive differences, such as reduced awareness of hunger and fullness may significantly contribute to feeding difficulties in children with ASD (Mahler, 2022).

However, the evidence within this study suggest that ASD individuals can be presented in one or a combination of all three ARFID subtypes, this evidence again supports the literature findings (Dinkler, 2022). The evidence presents a high overlap in subtypes with 10% of children experiencing sensory and low interest and 15% of children experiencing low interest and fear (Table 4). Some 25% had presented in an overlap of subtypes which supporting literature suggests that ASD children may experience multiple subtypes of ARFID (Dinkler, 2022). Thus, highlighting the complexity and heterogeneity of feeding difficulties within this population.

Fear-based avoidance was not the sole subtype that presented in the children; therefore, this may suggest that within this population restrictive eating is rarely driven by anxiety alone. Therefore, fear may represent in secondary factors solely driven by sensory sensitivity or reduced interoceptive awareness. It seems that fear/anxiety is

not a core ASD trait, and more a comorbid condition, this explains that fear may not appear on its own and it tends to co-occur with other difficulties (Menzel, 2024; Sanchez-Cerezo, 2024). The low prevalence of fear of aversive consequences (15%), and its absence as an independent presentation (Table 4), is consistent with literature suggesting that this subtype is more strongly associated with anxiety disorders rather than autism itself (Nocerino, 2024). This may explain why fear-based avoidance occurred only alongside other subtypes in this sample.

5.2 Gender findings

Research findings found that boys were significantly higher with ARFID presentations than girls with 65% boys and 35% of girls (Table 2). The higher proportion of boys relates to literature findings indicating a higher prevalence of autism diagnosis in males (Fredriksen, 2025). However, this may also reflect on the literature stating that females are under diagnosed than males of a ratio of 4;1 males; females who, in turn, may indicate masking behaviours and may contribute to under diagnosis in females found in research (Fredriksen, 2025; Galvin, 2022).

Over all the findings suggest that sensory-based avoidance is the most strongly associated subtype of ARFID found with children that have ASD and the findings of this study is consistent with the literature as Byttek-Matera highlights ARFID as a complex condition arising from the interaction of biological, psychological, and environmental factors and recognises that its subtypes are not always distinct but may co-occur with individuals (2022). However, the presences of over lapping subtypes and prevalence of low interest highlight the multifactorial nature of ARFID presentations in ASD and are rarely driven by a single mechanism but instead reflect their sensory processing differences, interoceptive awareness, and behavioural rigidity (Sader, 2025; Mahler, 2022; Dinkler, 2022; Koomar, 2021). These results indicate the need to support comprehensive, individualised assessment approaches that consider sensory, interoceptive, and psychological factors rather than treating individuals in just one ARFID category.

The qualitative findings within this study strongly highlight sensory processing differences as a primary driver of feeding difficulties with 12 out of the 20 (60%) (Table 3) of children experiencing sensory-based avoidance, this consists with the exciting data from the literature (Dinkler, 2022; Sader, 2025).

5.3 Interviews of Parent 1 and Parent 2

The thematic analysis of the interview data provided seven key themes related to feeding difficulties in children with ASD. These themes highlight the complexity of feeding behaviours and the interaction between sensory processing, physiological, emotional, and environmental factors.

Caregivers of the children within the interview study demonstrated clear aversions to texture, smell, and food presentation, with behaviours such as rejecting mixed foods, smelling food before eating, and preferring dry or finger foods (Parent 1, Parent 2). These findings align with existing literature findings identifying sensory sensitivities as a core feature of autism and a key mechanism underlying sensory-based ARFID (Dinkler, 2022; Sader, 2025).

The reliance on a narrow range of “safe foods” discussed in the interview (Parent 1 and 2) further reflects traits of characteristics of ARFID, where dietary variety is significantly limited. This supports previous findings that autistic children often present high levels of food selectivity, contributing to nutritional deficiencies and increased health risks (Nogueira-de-Almeida, 2025).

Mealtime emotional distress, including behaviours such as screaming and head banging (Parent 1 and 2), suggests that eating is not only a nutritional challenge but also a significant source of psychological and sensory stress. This supports literature indicating that sensory overload and rigidity in autism can lead to heightened emotional responses during feeding situations (Koomar, 2021). It is possible that this can contribute to fear of aversive consequences and develop an intense anxiety or phobia contributing to negative outcomes of eating (Gianneschi, 2024). This can be triggered by past traumatic past experiences with food such as what parent 1 and parent 2 explained during mealtimes this highlights that fear of aversive consequences can become a secondary response (Gianneschi, 2024; Sanchez-Cerezo, 2024).

Evidence of non-verbal hunger communication (Parent 2) and reduced awareness of internal states (Parent 1) support the role of interoceptive differences in feeding behaviours. This aligns with research suggesting that autistic individuals may have difficulty recognising hunger and fullness cues, contributing to the low-interest ARFID subtype (Mahler, 2022).

Physiological factors, including chronic constipation and food intolerances stated by Parent 2, were also identified as an influence to the child's eating behaviours. These findings are consistent with literature highlighting the high prevalence of gastrointestinal issues in autistic children and their impact on appetite and food intake (Tomaszek, 2025).

Both parents reported significant emotional burden, including anxiety, guilt, and frustration in accessing support. This aligns with literature research indicating that caregivers of autistic children with feeding difficulties often experience high levels of stress and must actively advocate for appropriate services (Bamigbade, 2024).

The reported lack of ongoing professional support highlights a gap in service to provide diagnosis and early interventions to ensure ARFID presentations do not become severe, as diagnostic overshadowing may result in feeding difficulties being solely ruled out by the child's autism which in turn may delay appropriate assessment and support (Arribas-Ayllon, 2025; Rajendram, 2021). Both parents expressed that there is little to no support and both expressed emotional stress towards this as Parent 2 explained having to advocate for their child and Parent 1 expressing there is no support (Appendix 1 and 2). This indicates a gap in support and intervention, despite evidence that early and consistent intervention is crucial for improving outcomes in both ASD and ARFID (Lidstone, 2025).

Feeding difficulties seems to extend beyond nutrition, impacting family routines, social participation, and school experiences (Koomar, 2021). This consists with the literature and reflects the broader psychosocial impact of ARFID, which can significantly affect quality of life for both the child and family (Watts, 2023).

5.4 Conclusion

Overall, the thematic analysis and qualitative findings support existing literature that feeding difficulties in autistic children are multifactorial, driven primarily by sensory sensitivities, interoceptive differences, and physiological factors. The presence of diagnostic overshadowing "they link it to his autism rather than identifying it separately" (Parent 2) and limited access to support (Parent 1) further exacerbates these challenges, as stated within the study there were children that did not experience feeding difficulties and in fact had healthy diets this proves that feeding difficulties are not linked solely to the child's autism. Importantly, the literature finding highlight the

need for early identification, multidisciplinary intervention, and greater clinical awareness of ARFID within autistic populations.

Chapter 6 Conclusion

The study explores the co-occurrence of ARFID and children that had ASD aged 3-6 years, with particular attention to ARFID sub types, underlying mechanisms, and lived experience of caregivers. Overall, the finding suggests that feeding difficulties in autistic children are complex and multifactorial.

The most significant finding within the study was sensory-based avoidance this sub type appeared to be the most prominent sub driver of ARFID presented in the children, followed closely to lack of interest of food. Fear of aversive consequences was less common and did not present independently within in this study, suggesting that in autistic children it may be a secondary sub type along with feeding difficulties rather than the primary driver. These findings support the literature that ARFID in ASD is strongly correlated to sensory processing differences, interoceptive difficulties, behavioural rigidity, physiological factors such as gastrointestinal discomfort, and environmental such as school mealtime settings which could relate to anxiety lead complications that correlate to fear of aversive consequences.

The qualitative findings from the thematic analysis further highlighted difficulties on everyday family life, as caregivers describe restrictive diets, the reliance on “safe foods”, meal time difficulties and distress at home and in school, difficulties in managing food intolerances especially in school settings as the caregiver (Parent 2) is unable to ensure the child is not eating anything out of other children’s lunch boxes, emotional burden, and the lack of support from professionals, claimed by both parents. The claims given by the caregiver further explains and exacerbates that feeding difficulties go way beyond nutritional deficiencies alone and that the effect it has can disrupt family routines, affect mental health within the child and caregivers, affect social life between the child and caregiver, and overall well-being.

The findings of this study suggest that, in autistic children, fear of aversive consequences may represent as a secondary response that develops alongside with other feeding difficulties, such as low interest or sensory sensitivities, rather than a primary driver of restrictive eating. The results highlight the complexities of ARFID with the identified presence of a secondary response. However, Important considerations should be noted as the study did rely on caregivers preceptive on how they feel their

child eating habits are. The data may not interpret the child's actual internal feeding experiences.

Despite these limitations, this study contributes to the growing body of research that there is a strong relationship between ARFID and ASD. The findings from the literature highlights the importance of early intervention, improved clinical awareness, and multidisciplinary support for children with ASD and experiencing feeding difficulties. Furthermore, a greater recognition and awareness of ARFID within the autistic population to help reduce diagnostic over shadowing and to ensure children are receiving timely and appropriate treatment and interventions. Further research is needed in larger samples and more diversity to further understand subtype presentation and how to treat, this could improve diagnostic treatment and inform and support families along with certain strategies to help reduce and help not to further ARFID symptoms into severe conditions such as anorexia or in some children's cases feeding tubes.

This study concludes that ARFID in children with ASD is a multifaced condition, with sensory-based avoidance being the sub driver, but can have over lapping subtype's, with other conditions that may be contributing such as secondary neurodevelopmental conditions, mental health conditions, and physiological influences. By recognising these complexities and contributions that may be influencing ARFID symptoms is essential for improving assessments to ensure the right treatment and intervention is taking place to try and avert long-term outcomes on this vulnerable population.

Word Count 7,355

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Appendices

Appendix 1 ARFID Brief Screener

Today's date (yymmdd):	Participant code (filled in by research staff):
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Questionnaire on eating problems in childhood

This questionnaire contains questions that describe certain eating problems in childhood. Tick the box that best describes your child's situation. If you find some of the questions difficult to answer, we still ask you to please try to answer them.

If you respond with "Yes, earlier", please also indicate at what age the respective problem or issue started and at what age it stopped.
 If you respond with "Yes, now", please also indicate at what age the respective problem or issue started.

	No, never	Yes, now	Yes, earlier	Started (age):	Stopped (age):
1. Do you think your child has or has had problems with eating characterized by avoidance or restriction of foods (i.e., that your child eats only a small range of foods or very little overall)?	☐	☐	☐		
2. Has any health professional (at preschool/school, BVC, or other health care) said that your child has problems with avoidant or restrictive eating?	☐	☐	☐		

If you replied "No, never" to **both** question 1 **and** 2, please continue with question 14.

	No, never	Yes, now	Yes, earlier	Started (age):	Stopped (age):
3. Have your child's eating habits led to your child losing weight, not gaining weight or not growing taller as they should?	☐	☐	☐		
4. Has any health professional said that your child has nutritional deficiencies due to their eating habits (e.g., vitamin or iron deficiency)?	☐	☐	☐		
5. Has your child been prescribed dietary supplements containing vitamins and/or minerals to address nutritional deficiencies?	☐	☐	☐		
6. Has your child required high-calorie supplements (e.g., nutritional drinks) to be able to maintain or gain weight?	☐	☐	☐		
7. After the age of 6 months, has your child required tube feeding (food or fluid via a tube in the nose or into the stomach) to maintain proper nutritional status?	☐	☐	☐		
8. Do your child's eating habits negatively affect their functioning almost daily (e.g., in preschool/school, activities with family/friends)?	☐	☐	☐		

Please answer question 9 only if your child is 6 years or older:

	No, never	Yes, now	Yes, earlier	Started (age):	Stopped (age):
9. Has your child ever restricted their eating because they wanted to lose weight or because they were afraid of gaining weight?	☐	☐	☐		

10. Do you suspect or know that your child's eating problems are primarily due to a medical condition or a mental disorder? ☐ No ☐ Yes

If yes, which one(s)? _____

	No, never	Yes, now	Yes, earlier	Started (age):	Stopped (age):
11. Does your child often avoid eating foods with certain smell, taste, appearance, temperature, or consistency/texture (e.g., crispy or soft)?	☐	☐	☐		
12. Does your child often avoid eating foods because they are worried about e.g., choking, vomiting/being sick, tummy aches, diarrhea, or an allergic reaction?	☐	☐	☐		
13. Does your child often eat too little because of low interest in eating and/or low appetite?	☐	☐	☐		

14. Has your child ever received a diagnosis because of difficulties with eating? ☐ No ☐ Yes

If yes, which one? _____

15. What is your relationship to the child? ☐ Mother ☐ Father

If other, who? _____

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Appendix 2 Parent 2 Interview Transcript

Interviewer:

Right, okay. So first question: can you tell me a little bit about your child their age, diagnosis, and any additional needs?

Parent:

So my child is four he'll be five in May. He's diagnosed with autism and Global Developmental Delay. He also struggles with food, not diagnosed as ARFID, but what they say are autism-related food sensitivities.

He tends to eat a lot of dry foods like finger foods. He likes to pick the batter off chicken nuggets and then throw the chicken away. He likes fries and toast he's very limited. He also likes sausages.

That's about it.

He does have a bit of a sweet tooth. At the moment, he's stuck on Jammy Dodgers. He likes to eat the jam out of the centre and throw the biscuit away. Sometimes he has Haribos. He used to like dairy-free chocolate, but he doesn't generally eat that anymore either.

So we are very, very limited. I give him vitamins on his toast.

Interviewer:

That's fine. When did you first notice difficulties with eating or food?

Parent:

He has pretty much always had some issues surrounding food. He has a milk intolerance, so he was breastfed for quite some time and didn't want to give it up. He was very difficult to feed as a baby.

He had lots of issues with withholding his stools and constipation, and he was under a consultant for some time for that. He does take medication to help him go regularly.

It's pretty much been ongoing since he started solid food.

Interviewer:

Has ARFID been identified?

Parent:

Yes. It's silly, but because he's autistic, they just put it down to sensory sensitivities linked to autism.

Interviewer:

How would you describe your child's current eating patterns?

Parent:

Very limited.

If I put something in front of him that I want him to eat, like a roast dinner it results in screaming, hitting his head, and kicking the baby gate in the hallway because he can't access the kitchen. He's telling me he's hungry without telling me he's hungry.

He's very picky. He likes what he likes.

Interviewer:

Are there any particular foods your child avoids or prefers?

Parent:

He won't eat anything with gravy or sauce. He doesn't eat beans anymore. He doesn't eat dairy-free cheese anymore.

He's very picky. If anything, it's gotten worse over time.

Interviewer:

How do sensory sensitivities such as texture, smell, colour, or temperature, affect his eating?

Parent:

He likes to smell everything. If it doesn't smell right, he will throw it.

He likes dry foods and doesn't like sauces. He eats with his fingers and doesn't use cutlery at all. If he doesn't like the feel, he throws it.

If I try to spoon-feed him, he will take the food back out of his mouth to feel it and smell it again. If it's not to his liking, he won't eat it.

Interviewer:

Have these eating behaviours changed over time?

Parent:

Yes, it's ongoing.

We have some weeks where it's very bad and stressful. I like to cook, but it's difficult. We do have good days. For example, if we go out for breakfast, he might have two pieces of toast and three sausages. So we have good days and bad days.

It also depends on whether he's been able to open his bowels.

Interviewer:

How has this affected your family's daily routines or social life?

Parent:

It's affected us because I can't cook in bulk like I used to. I like to make curries and things like that, but having children who are fussy means I'm limited.

I have to cook separate meals, which adds stress.

When we go out to eat, we have to make sure the place has something he can eat, that doesn't contain milk, and that he's willing to eat. It has had a massive impact.

Interviewer:

Has his eating behaviour impacted outings, holidays, or social events?

Parent:

Yes. We don't tend to do many social things because of his autism.

We always have to pick places that meet his dietary requirements. I have to check if food contains milk. For example, some chicken nuggets contain milk and some don't.

We tend to stick to the same places and don't try new places or foods.

It is quite difficult.

Interviewer:

How has this experience affected you personally as a mother?

Parent:

It's upsetting. I feel like I'm not giving my child the right vitamins and minerals his body needs to grow and thrive.

There's a lot of stress. As a parent, you want your child to eat a balanced meal, and that doesn't happen.

I have older children who loved fruit and vegetables. So having a child who is very picky is upsetting, because it feels like you're not doing enough.

Luckily, with the vitamins I give him on his toast, he hasn't developed serious deficiencies.

Interviewer:

What strategies have you tried to support his eating?

Parent:

If I'm making something separate for myself, I put a little bit on a separate plate for him so he has the option to try.

Sometimes, if he likes the look of my food, he will touch or try it. I allow that because he's trying.

I do offer other things, but at the moment I tend to stick to what he likes to avoid distress.

We've spoken to a dietitian, who advised offering food without pressure and giving him options.

Interviewer:

What support have you received from school?

Parent:

School are aware of his needs and dietary requirements.

It can be difficult when other children bring food containing milk. He has accessed other children's lunchboxes before, which upset his stomach.

I send a packed lunch when he's there all day, but he doesn't eat much of it either.

It's really difficult.

Interviewer:

What kind of information or support do you feel is missing?

Parent:

As an autism parent, I feel like I'm constantly fighting for information and support.

I've been sent leaflets, but I think regular intervention would help, like regular checks for deficiencies and ongoing dietitian support.

It would also help if schools could provide better meal options for children with eating difficulties, because sending packed lunches is difficult when he only eats limited foods.

Interviewer:

Final question: is there anything else you feel is important to share?

Parent:

No, I think that's everything.

Interviewer:

I'd like to thank you for taking part in this interview and if you have any questions feel free to ask me.

Parent:

Ok thank you.

Interviewer:

Thank you.

Appendix 3 Parent 1 Interview Transcript

Researcher:

Could you tell me a little bit about your child, including their age, diagnosis, and any additional needs?

Participant:

My child is five years old. She has been diagnosed with global developmental delay and autism. ADHD is also suspected, but she cannot be formally diagnosed until she is seven.

Researcher:

When did you first notice difficulties with eating?

Participant:

I noticed it around 18 months old. Before that, she would eat everything and anything I put in front of her. Then, around 18 months, her food intake started to reduce, and she became very picky.

Now she mainly eats beige foods such as pasta with cheese, rice with cheese, and super noodles. Occasionally, she will eat a Cornbeef pasty, but that is rare. She doesn't eat meat or vegetables at all. She will eat chicken nuggets from McDonald's, but if I make them at home, she won't eat them. She also eats certain crisps, likes wositis or Skips, and specific biscuits like Jammy Dodgers, and occasionally chocolate.

Researcher:

How would you describe your child's current eating patterns?

Participant:

She is more of a grazer she eats small amounts throughout the day. I try to encourage her to sit at the table and eat properly, but it is very hit and miss.

Researcher:

Are there any particular foods your child avoids or prefers?

Participant:

She avoids all types of meat unless it's chicken nuggets from McDonald's. Sometimes

she'll eat a corn beef pasty, but only from Greggs, not anywhere else. She won't eat vegetables at all.

She prefers beige foods and won't eat foods mixed together for example, she won't eat pizza. Trying to introduce new foods is very difficult, and she will often shout or refuse.

Researcher:

How do sensory sensitivities such as texture, smell, colour, or temperature affect her eating?

Participant:

Temperature definitely affects her eating. If food is too hot, she will shout, so it has to be quite cool. For example, she likes super noodles, but she will only eat them cold.

She also doesn't like very cold foods she won't eat ice cream. Even when she was teething as a baby, she didn't like cold items in her mouth. She will eat yoghurt, but only if it's closer to room temperature rather than straight from the fridge.

Smell doesn't seem to affect her as much. I cook a lot of food, and she tolerates the smell. Texture seems more important she prefers soft foods like pasta, rice, and noodles. Her diet is also very beige in colour, and she avoids more vibrant foods.

Researcher:

Have these eating behaviours changed over time?

Participant:

Yes. She used to eat a wide variety of foods, but over time things gradually reduced. Foods she used to eat, like chilli or spaghetti with sauce, she no longer eats. It has slowly become more restricted.

Researcher:

How has this affected your family's daily routines or social life?

Participant:

We can't really go out for meals. She gets very upset and has meltdowns, partly due to noise. Ear defenders help, but we still have to keep her distracted.

Routine is very important for her. She relies on familiar foods, which I think are her “safe foods.” It’s usually the same few foods each time.

Holidays can also be difficult. We went on a caravan holiday for three days, and going out for food was very challenging. She would scream and become distressed, although she did enjoy other parts of the holiday.

Researcher:

How has this experience affected you personally?

Participant:

It’s very upsetting as a mother. I worry about her nutrition and whether she is getting enough vitamins. I do try my best to introduce different foods, but it is a big struggle.

Researcher:

What strategies have you tried to support her eating?

Participant:

I try not to put too much pressure on her. If she refuses food, I don’t force her. Recently, she tried a roast potato, which was a big achievement, and I praised her a lot.

I try to slowly introduce new foods. I also let her help with cooking so she becomes more familiar with food.

We have seen a dietitian, who gave some strategies, but there isn’t much support specifically for ARFID. They said it is still a relatively new diagnosis and not much is known.

Researcher:

What support have you received from school?

Participant:

Not much. I pack her lunch every day with the same foods. She doesn’t eat in the hall because it is too loud, so she eats in a quieter room.

Researcher:

What kind of information or support do you feel is missing?

Participant:

There's a lack of support. It feels like a guessing game trying different things to see what works. Since her diagnosis, I haven't received much help. You have to find support yourself, which is very distressing. It feels like you're constantly fighting and not getting anywhere.

Researcher:

Is there anything else you would like to add?

Participant:

No, I think we've covered everything.

Researcher:

Thank you for your time to take part in this interview.

Participant:

Thank you.

Appendix 4 Ethical Approval

APPLICATION FOR ETHICAL APPROVAL

In order for research to result in benefit and minimize risk of harm, it must be conducted ethically. A researcher may not be covered by the University's insurance if ethical approval has not been obtained prior to commencement.

The University follows the OECD Frascati manual definition of **research activity**: "creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications". As such this covers activities undertaken by members of staff, postgraduate research students, and both taught postgraduate and undergraduate students working on dissertations/projects.

The individual undertaking the research activity is known as the "principal researcher".

Ethical approval is not required for routine audits, performance reviews, quality assurance studies, testing within normal educational requirements, and literary or artistic criticism.

Please read the notes for guidance before completing ALL sections of the form.

This form must be completed and approved prior to undertaking any research activity. Please see Checklist for details of process for different categories of application.

SECTION A: About You (Principal Researcher)

1	Full Name:	Maralyn Anderson
2	Undergraduate Student	☒
3	Institute/Academic Discipline/Centre:	Institute of management and health
4	Campus:	University of Wales trinity saint David
5	E-mail address:	2210083
For students:		
7	Student Number:	2210083
8	Programme of Study:	Health nutrition and lifestyle
9	Project Supervisor:	Chris Cashin

SECTION B: Approval for Research Activity

1	Has the research activity received approval in principle by a member of staff?	YES	☒	NO	☐
	Date			29/11/2025	

SECTION C: Internal and External Ethical Guidance Materials

	Please list the core ethical guidance documents that have been referred to during the completion of this form (including any discipline-specific codes of research ethics, location-specific codes of research ethics, and also any specific ethical guidance relating to the proposed methodology). Please tick to confirm that your research proposal adheres to these codes and guidelines. You may add rows to this table if needed.	
1	UWTSD Research Ethics & Integrity Code of Practice	☒
2	UWTSD Research Data Management Policy	☒
3	Subject specific resources if applicable:	☒

SECTION D: Details of Research Activity

1	Indicative title:			
2	Proposed start date:	December 2025	Proposed end date:	April 2026
	Introduction to the Research (maximum 300 words per section) Ensure that you write for a <u>Non-Specialist Audience</u> when outlining your response to the points below: • Purpose of Research Activity • Proposed Research Question • Aims of Research Activity • Objectives of Research Activity Demonstrate, briefly, how Existing Research has informed the proposed activity and explain • What the research activity will add to the body of knowledge • How it addresses an area of importance.			
3	Purpose of Research Activity To investigate and identify if ARFID and ASD co-occur.			
4	Research Question How prevalent is ARFID among children with ASD and do both the primary sensory factors within the two conditions link together. How does ARFID affect nutritional status with children with ASD. Are there any strategies to overcome ARFID and can there be more put in place for interventions and diagnosis.			
5	Aims of Research Activity The aim of this research is to explore whether there is a link between the factors contributing to the presence of ARFID in a group of school-aged children diagnosed with ASD. This study will explore whether there is any connection between the sensory or behavioural issues associated with ALFID and the ASD school children.			

	(this box should expand as you type)
6	Objectives of Research Activity To investigate whether sensory sensitivities are associated with restrictive eating behaviors in children with ASD. To explore the behavioral and emotional patterns that may contribute to ARFID symptoms in autistic children. To contribute to the understanding of co-occurring ASD and ARFID to inform future screening and intervention practices. (this box should expand as you type) Proposed methods (maximum 600 words) Provide a brief summary of all the methods that may be used in the research activity, making it clear what specific techniques may be used. If methods other than those listed in this section are deemed appropriate later, additional ethical approval for those methods will be needed. You do not need to justify the methods here, but should instead describe how you intend to collect the data necessary for you to complete your project.
7	A minimum of 20 parents or primary caregivers of children diagnosed with ASD will be recruited to complete a questionnaire. • Age range: 3–6 years old (school-aged). • This age range was chosen to identify whether ARFID symptoms are within this age range. All participants will be ensured their information will be stored with anonymity and confidentiality maintained, before signing their consent. All participants will be given a pre-existing questionnaire, ARFID brief screener (NIAS) (Zickgraf and Ellis, 2018) in order to compare findings. These participants in this study will be mothers or caregivers at a Welsh primary school that the researcher has access to. To gain more data online access to e.g. groups on social media will also be conducted using the same strategy as the face-to-face participant via email online. • Informed consent will be obtained from all participating parents or guardians. • Participants will have the right to withdraw at any stage. • Data will be anonymised and securely stored under a password so all data will be protected. • Ethical approval will be approved from the university's research ethics committee before recruitment begins. Participants will complete a questionnaire designed to explore: • Feeding behaviours (food selectivity, avoidance, rigidity). • Sensory sensitivities (taste, texture, smell, and visual aspects of food). • Anxiety or fear-related behaviours around food. • Age, gender, diagnosis history.
	Location of research activity Identify all locations where research activity will take place.
8	School parents, and online groups.

	Research activity outside of the UK If research activity will take place overseas, you are responsible for ensuring that local ethical considerations are complied with and that the relevant permissions are sought. Specify any local guidelines (e.g. from local professional associations/learned societies/universities) that exist and whether these involve any ethical stipulations beyond those usual in the UK (provide details of any licenses or permissions required). Also specify whether there are any specific ethical issues raised
	by the local context in which the research activity is taking place, for example, particular cultural and/or legal sensitivities or vulnerabilities of participants. If you live in the country where you will do the research then please state this.
9	N/A <i>(this box should expand as you type)</i>

10	Use of documentation not in the public domain: Are any documents NOT publicly available?	NO	☒
		YES	☐
11	If Yes, please provide details here of how you will gain access to specific documentation that is not in the public domain and that this is in accordance with the current data protection law of the country in question and that of England and Wales. <i>(this box should expand as you type)</i>		

	Does your research relate to one or more of the seven aims of the Well-being of Future Generations (Wales) Act 2015?	YES	NO
12	A prosperous Wales	☒	☐
13	A resilient Wales	☐	☐
14	A healthier Wales	☒	☐
15	A more equal Wales	☒	☐
16	A Wales of cohesive communities	☐	☐
17	A Wales of vibrant culture and thriving Welsh language	☐	☒
18	A globally responsible Wales	☒	☐

SECTION F: Scope of Research Activity

	Will the research activity include:	YES	NO
1	Use of a questionnaire or similar research instrument?	☒	☐
2	Use of interviews?	☐	☒
3	Use of focus groups?	☒	☐
4	Use of participant diaries?	☐	☒
5	Use of video or audio recording?	☐	☒
6	Use of computer-generated log files?	☒	☐

7	Participant observation with their knowledge?	☐	☒
8	Participant observation without their knowledge?	☐	☒
9	Access to personal or confidential information without the participants' specific consent?	☐	☒
10	Administration of any questions, test stimuli, presentation that may be experienced as physically, mentally or emotionally harmful / offensive?	☐	☐
11	Performance of any acts which may cause embarrassment or affect self-esteem?	☐	☒
12	Investigation of participants involved in illegal activities?	☐	☒
13	Use of procedures that involve deception?	☐	☒
14	Administration of any substance, agent or placebo?	☐	☒
15	Working with live vertebrate animals?	☐	☒
16	Procedures that may have a negative impact on the environment?	☐	☒
17	Other primary data collection methods. Please indicate the type of data collection method(s) below.	☐	☒
	Details of any other primary data collection method: (this box should expand as you type)		

If NO to every question, then the research activity is (ethically) low risk and **may** be exempt from **some** of the following sections (please refer to Guidance Notes).

If YES to any question, then no research activity should be undertaken until full ethical approval has been obtained.

SECTION G: Intended Participants

If there are no participants then do not complete this section, but go directly to section H.

	Who are the intended participants:	YES	NO
1	Students or staff at the University?	☐	☒

2	Adults (over the age of 18 and competent to give consent)?	☐	☒
3	Vulnerable adults?	☐	☒
4	Children and Young People under the age of 18? (Consent from Parent, Carer or Guardian will be required)	☒	☐
5	Prisoners?	☐	☒
6	Young offenders?	☐	☒
7	Those who could be considered to have a particularly dependent relationship with the investigator or a gatekeeper?	☐	☒
8	People engaged in illegal activities?	☐	☒
9	Others. Please indicate the participants below, and specifically any group who may be unable to give consent.	☐	☒
	Details of any other participant groups: (this box should expand as you type)		

	Participant numbers and source Provide an estimate of the expected number of participants. How will you identify participants and how will they be recruited?	
10	How many participants are expected?	20 or above.
11	Who will the participants be?	Mothers will be filling the questionnaire on behalf of their child
12	How will you identify the participants?	Social media and school.

	Information for participants:	YES	NO	N/A
13	Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	☒	☐	☐
14	Will you tell participants that their participation is voluntary?	☒	☐	☐
15	Will you obtain written consent for participation?	☒	☐	☐
16	Will you explain to participants that refusal to participate in the research will not affect their treatment or education (if relevant)?	☒	☐	☐
17	If the research is observational, will you ask participants for their consent to being observed?	☒	☐	☐
18	Will you tell participants that they may withdraw from the research at any time and for any reason?	☒	☐	☐
19	With questionnaires, will you give participants the option of omitting questions they do not want to answer?	☒	☐	☐

20	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	☒	☐	☐
21	Will you debrief participants at the end of their participation, in a way appropriate to the type of research undertaken?	☒	☐	☐
22	If NO to any of above questions, please give an explanation			
	(this box should expand as you type)			

	Information for participants:	YES	NO	N/A
24	Will participants be paid?	☐	☒	☐
25	Is specialist electrical or other equipment to be used with participants?	☐	☒	☐
26	Are there any financial or other interests to the investigator or University arising from this study?	☐	☒	☐
27	Will the research activity involve deliberately misleading participants in any way, or the partial or full concealment of the specific study aims?	☐	☒	☐
28	If YES to any question, please provide full details			
	(this box should expand as you type)			

SECTION H: Anticipated Risks

	Outline any anticipated risks that may adversely affect any of the participants, the researchers and/or the University, and the steps that will be taken to address them. If you have completed a full risk assessment (for example as required by a laboratory, or external research collaborator) you may append that to this form.					
1	Full risk assessment completed and appended?	<table border="1"> <tr> <td>Yes</td> <td>☒</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> </table>	Yes	☒	No	☐
Yes	☒					
No	☐					
2	Risks to participants For example: sector-specific health & safety, emotional distress, financial disclosure, physical harm, transfer of personal data, sensitive organisational information					
	Risk to participants: The participant may be affected emotionally and mentally relating to their child.	How you will mitigate the risk to participants: Explain to the participant where to receive any help that's available e.g. GP, NHS sites to help. (this box should expand as you type)				
3	If research activity may include sensitive, embarrassing or upsetting topics (e.g. sexual activity, drug use) or issues likely to disclose information requiring further action (e.g. criminal activity), give details of the procedures to deal with these issues, including any support/advice (e.g. helpline numbers) to be offered to participants. Note that where applicable, consent procedures should make it clear that if something potentially or actually illegal is discovered in the course of a project, it may need to be disclosed to the proper authorities					

	If parent/ care giver of the child may become distressed or emotionally effected by the procedure, then I will give advice on where they may find help. Within the school that I will be collecting data from there will be professionals in the facility that can also help the parent/ caregiver on advice and where to seek help.		
4	Risks to the investigator For example: personal health & safety, physical harm, emotional distress, risk of accusation of harm/impropriety, conflict of interest		
	Risk to the investigator: Harassment to the other participant <i>(this box should expand as you type)</i>	How you will mitigate the risk to the investigator: The investigator will be with in a school with other professionals within the room there will be people around so danger is minimised <i>(this box should expand as you type)</i>	
5	University/institutional risks For example: adverse publicity, financial loss, data protection		
	Risk to the University: If the investigator was rude to the participant or did not do the questionnaire in a professional manner <i>(this box should expand as you type)</i>	How you will mitigate the risk to the University: Ensure all guidelines are met in a professional manner <i>(this box should expand as you type)</i>	
6	Environmental risks For example: accidental spillage of pollutants, damage to local ecosystems		
	Risk to the environment: Disposal of paper forms <i>(this box should expand as you type)</i>	How you will mitigate the risk to environment: Ensure paper forms will be disposed properly and recycled	
		<i>(this box should expand as you type)</i>	

	Disclosure and Barring Service			
	If the research activity involves children or vulnerable adults, a Disclosure and Barring Service (DBS) certificate must be obtained before any contact with such participants.	YES	NO	N/A
7	Does your research require you to hold a current DBS Certificate?	☐	☒	☐
8	If YES, please give the certificate number. If the certificate number is not available please write "Pending"; in this case any ethical approval will be subject to providing the appropriate certificate number.			

SECTION I: Feedback, Consent and Confidentiality

1	Feedback What de-briefing and feedback will be provided to participants, how will this be done and when?
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	The feed back provided to the participants will be done at the end of the questionnaire I will explain if they would like to see the results they can and if they would like to know what I have found within the research I could contact them VIA email if they wish.
2	Informed consent Describe the arrangements to inform potential participants, before providing consent, of what is involved in participating. Describe the arrangements for participants to provide full consent before data collection begins. If gaining consent in this way is inappropriate, explain how consent will be obtained and recorded in accordance with prevailing data protection legislation.
	Full consent will be obtained, and the investigator will explain the whole procedure and how consent and full confidentiality will be obtained if the participant chooses to opt out then all information will be destroyed relating to the participant.
3	Confidentiality / Anonymity Set out how anonymity of participants and confidentiality will be ensured in any outputs. If anonymity is not being offered, explain why this is the case.
	full confidentiality will be obtained if the participant chooses to opt out then all information will be destroyed relating to the participant.

SECTION J: Data Protection and Storage

	Does the research activity involve personal data (as defined by the General Data Protection Regulation 2016 "GDPR" and the Data Protection Act 2018 "DPA")?	YES	NO
1	"Personal data" means any information relating to an identified or identifiable natural person ('data subject'). An identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person. Any video or audio recordings of participants is considered to be personal data.	☐	☐
	If YES, provide a description of the data and explain why this data needs to be collected:		
2	NO <i>(this box should expand as you type)</i>		
	Does it involve special category data (as defined by the GDPR)?	YES	NO
3	"Special category data" means sensitive personal data consisting of information as to the data subjects' – (a) racial or ethnic origin, (b) political opinions, (c) religious beliefs or other beliefs of a similar nature, d. membership of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992), e. physical or mental health or condition, f. sexual life, g. genetics, h. biometric data (as used for ID purposes),	☐	☐

	If YES, provide a description of the special category data and explain why this data needs to be collected:
4	Yes, Information that is given is from mothers of children with ASD or awaiting and assessment for diagnosis and possible ARFID.

	Will data from the research activity (collected data, drafts of the thesis, or materials for publication) be stored in any of the following ways?	YES	NO
5	Manual files (i.e. in paper form)?	☒	☐
6	University computers?	☐	☒
7	Private company computers?	☐	☒
8	Home or other personal computers?	☒	☐
9	Laptop computers/ CDs/ Portable disk-drives/ memory sticks?	☒	☐
10	"Cloud" storage or websites?	☐	☒
11	Other – specify:	☐	☒
12	For all stored data, explain the measures in place to ensure the security of the data collected, data confidentiality, including details of backup procedures, password protection, encryption, anonymisation and pseudonymisation:		
	All participants will be anonymised; data will be stored on personal laptop under a password. All paper forms once stored in laptop will destroyed and once data has been used through spss then anything that is on excel will be discarded. <i>(this box should expand as you type)</i>		

	Data Protection		
	Will the research activity involve any of the following activities:	YES	NO
13	Electronic transfer of data in any form?	☐	☒
14	Sharing of data with others at the University outside of the immediate research team?	☒	☐
15	Sharing of data with other organisations?	☐	☒
16	Export of data outside the UK or importing of data from outside the UK?	☐	☒
17	Use of personal addresses, postcodes, emails or telephone numbers?	☐	☒
18	Publication of data that might allow identification of individuals?	☐	☒
19	Use of data management system?	☐	☒
20	Data archiving?	☐	☒
21	If YES to any question, please provide full details, explaining how this will be conducted in accordance with the GDPR and Data Protection Act (2018) (and any international equivalents, where appropriate):		
	Investigations supervisor will be observing information. <i>(this box should expand as you type)</i>		

22	List all who will have access to the data generated by the research activity:		
	Myself and supervisor. <i>(this box should expand as you type)</i>		
23	List who will have control of, and act as custodian(s) for, data generated by the research activity:		
	Myself. <i>(this box should expand as you type)</i>		
24	Give details of data storage arrangements, including security measures in place to protect the data, where data will be stored, how long for, and in what form. Will data be archived – if so how and if not why not.		
	All data will be stored in a personal laptop under a password and all paper form questionnaires will be stored under lock and key before distributing all paper form data into laptop and all paper form will be destroyed and recycled. <i>(this box should expand as you type)</i>		
25	Please indicate if your data will be stored in the UWTSD Research Data Repository (see https://researchdata.uwtsd.ac.uk/). If so please explain. <i>(Most relevant to academic staff)</i>		
	No <i>(this box should expand as you type)</i>		
26	Confirm that you have read the UWTSD guidance on data management (see https://www.uwtsd.ac.uk/library/research-data-management/)	YES	☒